MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (X) HCP ( ) IE ( ) IC	**Response Timely Filed?** ( ) Yes ( ) No
Requestor's Name and Address Houston Premier DME 4141 North Freeway, Ste. 206 Houston, TX 77022	MDR Tracking No.: M4-04-0863-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Box 47 American Casualty Company of Reading PA	Date of Injury: Employer's Name: O-Reilly Automotive Inc Insurance Carrier's No.: 3C805592

PART II: SUMMARY OF DISPUTE AND FINDINGS

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
9/18/02	9/18/02	L4350	250.00	250.00

PART III: REQUESTOR'S POSITION SUMMARY

Patient was set up with an ankle splint. The EOBs rationale stated "E – entitlement (non-compensable)." This issue has been resolved after a CCH was held. On 8/25/03, the Decision and Order was handed down by TWCC.

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier maintains disputed – Achilles tendon – peer review attached, TWCC-21 attached.

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Review of the CCH Decision and Order, dated August 25, 2003, states in part "As noted above the doctors have confirmed a right ankle sprain and Achilles tendon strain that encompassed both the ankle and the heel. Claimant established that he sustained an injury to the right heel and ankle in the work incident of ___."

The dispute over the Achilles tendon has been finally adjudicated. The compensable injury extends to the Achilles tendon as indicated in the CCH Decision. The Respondent did not appeal this decision, however, they have filed another TWCC-21 to re-adjudicate this matter and a Benefit Review Conference is pending.

The disputed DME item is subject to fair and reasonable reimbursement. The Respondent did not question the fair and reasonable and raised no other valid reason for denying reimbursement in their audit of the bill.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to reimbursement in the amount of **$250.00.** The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Patti Lanfranco	June 28, 2005
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
P.O. Box 17787
Austin, Texas, 78744
or faxed to (512) 804-4011
A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART VIII: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____